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## American forensic social workers' knowledge of and skepticism toward dissociative identity disorder

Amy Lee Consolati

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AMERICAN FORENSIC SOCIAL WORKERS' KNOWLEDGE OF  
AND SKEPTICISM TOWARD DISSOCIATIVE  
IDENTITY DISORDER

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A Project  
Presented to the  
Faculty of  
California State University,  
San Bernardino

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In Partial Fulfillment  
of the Requirements for the Degree  
Master of Social Work

---

by  
Amy Lee Consolati

June 2005

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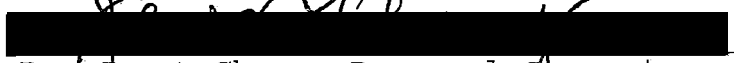
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## ABSTRACT

As hypothesized, there was an inverse relationship between knowledge and skepticism. The present findings differ from previous studies such that age and theoretical orientation did not affect knowledge and skepticism. The distribution of skepticism responses was bimodal, suggesting that a controversy remains. Potential differences between forensic and non-forensic social workers are discussed.

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## CHAPTER ONE

### INTRODUCTION

The controversy surrounding the diagnosis of Dissociative Identity Disorder (DID) is discussed, as well as micro-, macro- and policy-practice issues surrounding the diagnosis and the controversy. Studies about psychologists' and psychiatrists' attitudes toward DID are reviewed and a gap in the literature concerning social workers' attitudes is identified. It is important to identify their levels of knowledge and skepticism because of the high level of client contact they experience and the impact that their thinking may have on the diagnosis, treatment and legal outcomes of clients.

#### Problem Statement

##### The Dissociative Identity Disorder Controversy

Multiple personality syndrome captured public attention in 1811 with the case of Mary Reynolds (Carlson, 1981). After the well-publicized Reynolds case, the rate of diagnoses increased until 1910 when Bleuler, (as cited in Rosenbaum, 1980) introduced the concept of schizophrenia. Then, between 1911 and 1978, the frequency of multiple personality syndrome diagnoses decreased as



the diagnoses of schizophrenia increased (Carlson, 1981; Rosenbaum, 1980).

In 1980, the American Psychiatric Association (APA) added the diagnosis of multiple personality disorder (MPD) to the third edition of the Diagnostic and Statistical Manual [DSM III] (APA, 1980). This launched a controversy between believers in and skeptics of the diagnosis that has maintained momentum to this day. Clinicians are increasing their rate of diagnosing the once rare condition at a steady pace while researchers are working furiously to prove that it is nothing more than a product of iatrogenesis, imagination or fantasy (Kluft, 2003; Severino, 2003).

In the early 1990s, researchers and clinicians met in formal debates to determine whether MPD should be included in the upcoming DSM IV (APA, 1994). In the end, a disorder was included at some cost to both sides. The DSM IV (APA, 1994) no longer included MPD however; the similar yet arguably different diagnosis of DID took its place (Allison, 1996, 1998, 2001).

#### Micro, Macro and Policy Contexts

In forensic mental health service delivery settings, interdisciplinary or multidisciplinary teams may work

together to provide services for clients with chronic and severe mental illness. Interdisciplinary teams consist of psychiatrists; psychologists; social workers; pharmacists; registered nurses; recreational, occupational and rehabilitation therapists; and psychiatric technicians. In highly integrated and forward-thinking settings, multidisciplinary teams may additionally include other service providers who interact with clients such as nutritionists and food-service workers, and custodial and maintenance personnel (Zeiss, 1997).

The team approach to service delivery has several advantages. For example, teamwork can provide a broad range of assessment data and treatment planning perspectives that can result in well-informed and reality-based diagnoses and treatment decisions. Additionally, it can help to ensure consistent reinforcement of treatment goals, strategies and tactics throughout the client's environment (Zeiss, 1997).

The social worker on an interdisciplinary team often provides most of the applied services. In other words, the social worker has more client contact than other team members do. For instance, they frequently provide

individual, family and group psychotherapy and they often perform nearly all-case management duties. Additionally, social workers routinely interact with the courts and the community on behalf of clients in the interest of facilitating or inhibiting their re-entry into free society (Madden & Wayne, 2003).

As noted above, there is an unresolved controversy among mental health professionals regarding the diagnosis of DID. Also noted is that forensic social workers are fundamental members of interdisciplinary or multidisciplinary treatment teams and as such often provide face-to-face treatment for clients. Further, the intimate nature of the relationship between a client and social worker frequently renders social workers' testimony necessary to resolve certain legal issues.

Social psychology's attitude-behavior theory suggests a predictive link between attitudes and behavior (Baron & Byrne, 2000; Vargas, von Hippel, & Petty, 2004). Assuming this, it is reasonable to assert that social workers' attitudes toward DID may affect the diagnoses, treatment and testimony they provide for their clients. Further, the attitudes of other team members may interfere with or influence social workers' attitudes,

thus complicating the matter even more. Therefore, this study sought to determine forensic social workers' levels of knowledge about and skepticism toward DID.

#### Purpose of this Study

The purpose of this study was to examine forensic social workers' levels of knowledge about and skepticism toward DID in light of the controversy that surrounds the diagnosis. Relationships between demographic and professional practice variables and workers' levels of knowledge and skepticism were analyzed to assess the possible etiology of skepticism toward DID.

Forensic social workers' attitudes are particularly relevant to the DID controversy because of the serious ramifications they may have on the legal outcomes of their clients. In the case of trials for criminal behavior, a defendant's sanity is sometimes at issue. Legal factors relating to sanity (or lack of) include the right to be Mirandized, to testify on one's own behalf and plead guilty but not guilty by reason of insanity. Other important legal issues in the case of DID is one's criminal responsibility and malingering (Behnke, 1997; Coons, 1991; Dawson, 1999; James 1998; Kennett &

Matthews, 2002; Noonan, 2000; Owens, 1997; Saks, 1995; Savitz, 1990; Serban, 1996; Sinnott-Armstrong & Behnke, 2000; Slovenko, 1995; Steinberg, Bancroft, & Buchanan, 1993).

In the case of DID, the above the legal factors become very complicated. If a person has the diagnosis prior to arrest, questions arise as to which identity has the right to be Mirandized, and found legally sane or insane. Which identity is the criminally responsible agent and which one or ones should testify? Who should serve time in prison, be granted parole or put to death?

If a person does not have a diagnosis of DID prior to arrest, malingerer is always a possibility and yet is very difficult to ascertain in the court setting (Allison, 1984; Coons, 1991; Labott & Wallach, 2002; Thomas, 2001). The generally accepted etiology of DID is severe trauma in which the person believes that their life is in danger (APA, 1994). Given this, how does one determine if a defendant is feigning DID to get life versus death or if the very real and traumatic circumstance of facing death has indeed caused DID (Allison, 1984)?

To resolve these issues yet another revision of the diagnostic criteria for DID may be necessary to assure the utmost clarity and objectivity (Dell, 2001). However, as long as a division of professionals' opinions remains as to the very existence of DID, this process will continue to be arduous.

The long-standing controversy about DID has prompted a substantial number of studies in the United States about mental health professional's attitudes, beliefs and skepticism toward the disorder (Cormier & Thelen, 1998; Dell, 1988; Dunn, Paolo, Ryan, & Van Fleet, 1994; Hayes & Mitchell, 1994; LeLonde, Hudson, Gegante, & Pope, 2001; McMinin & Wade, 1995; Pope, Oliva, Hudson, Bodkin, & Gruber, 1999). All of the studies verify that a controversy is in play.

While these studies are useful gauges of attitudes, beliefs and skepticism among psychiatrists and psychologists, Hayes and Mitchell's (1994) is the only one that addresses social workers. It worth noting here that Dell's (1988) study may or may not include social workers because he categorized his participants as psychiatrists, psychologists, and "master's degree therapists" (p. 528).

Forensic social workers are nearly always part of treatment teams in forensic mental health treatment settings and often have more client contact than other members of the team have. As a result, they acquire detailed knowledge about clients. This in turn, often leads the courts to subpoena their expert testimony for legal proceedings. Frequently, the decisions reached in these proceedings have serious or grave consequences for clients. Therefore, social workers' attitudes toward the diagnosis of DID could affect clients on many levels including diagnoses, treatment and legal outcomes. This makes the present study of their knowledge about and attitudes toward DID germane to forensic social work practice. Thus, this study sought to determine forensic social workers' attitudes toward the diagnosis of DID.

Data for this study was collected by mailing a survey instrument to individuals who self-identified as forensic social workers by maintaining membership in the National Organization of Forensic Social Workers (NOFSW). The survey instrument was an adapted version of the one used in the Hayes and Mitchell (1994) quantitative knowledge and skepticism study. This method of collection provided data from a geographically diverse population

and thus, made the results relevant for many American forensic social workers.

#### Significance of this Project for Social Work

As noted above, there is a scant amount of research that examines social workers' knowledge of or skepticism toward the diagnosis of DID. Further, the previous research is only in the psychology literature. Attitude, belief and skepticism studies about DID were entirely absent from the social work literature. This study therefore, sought to illuminate this as a social work issue and to begin filling the void.

The results of this study may assist social work practitioners in recognizing their own prejudicial attitudes that could have latent effects on the assessment and diagnoses, implementation of intervention(s), evaluation of treatment efficacy, and testimony they provide for their clients. For example, a practitioner who is an opponent or skeptic of DID might deny or rationalize when a client fully meets the diagnostic criteria for DID and erroneously defer the diagnosis to schizophrenia or bi-polar disorder. Similarly, an extreme proponent may seek confirmation of



vague symptoms or worse, create symptoms of DID in their clients through iatrogenesis.

This study may also persuade agencies that treat forensically committed clients to examine the motivation behind their policies that encourage or discourage various diagnoses. In the case of DID, treatment is generally under the psychoanalytical or the psychodynamic models, which are normally long-term treatments. Agencies might thus encourage under-diagnosis of DID simply because it is inconvenient to treat it. In such a scenario it is difficult to determine which came first, the negative attitude toward DID or the need to fit clients' diagnoses to treatments that are easy to apply.

Three hypotheses were formulated: a) an inverse relationship would exist between skepticism toward, and knowledge of DID; b) forensic social workers who have been in practice longer would be more skeptical and less knowledgeable; c) practitioners with a psychoanalytic and/or psychodynamic theoretical orientation would be more knowledgeable and less skeptical than those with other theoretical orientations.

## CHAPTER TWO

### LITERATURE REVIEW

#### Introduction

Diagnostic and legal issues, and professionals' knowledge of and attitudes toward DID are discussed. In addition, conceptual theories of dissociation and the link between attitudes and behavior are discussed.

#### Diagnostic Issues

The DSM IV (APA, 1994) diagnostic criteria for DID include four items. Criterion A requires the "presence of two or more distinct identities or personality states" within the person. Criterion B indicates, "at least two of these identities or personality states recurrently take control of the person's behavior" (p. 529). It is noteworthy that criteria A and B reflect the essence of the entire diagnostic criteria that were in DSM III (APA, 1980). Criteria C and D are additions made to the diagnosis in the fourth edition of the DSM IV (APA, 1994). Criterion C indicates the "inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness." The final criterion (D) is that the "disturbance is not due to the

direct physiological effects of a substance...or a general medical condition" (p. 529).

Allen and Iacono (2001) challenged criterion C by reviewing several objectively verifiable memory tests and found that most individuals diagnosed with DID exhibited at least some interidentity memory. Further, they proposed that if objective measures of memory between alter-identities were required for diagnosis rather than self-reporting; very few cases would meet all four of the DSM IV (APA, 1994) criteria. Finally, they suggested a revision of the criteria that would modify or eliminate criterion C, or add a sub diagnosis of DID NOS (not otherwise specified) that would apply to diagnosable individuals who have interidentity memory.

Huntjens, Postma, Peters, Woertman, and van der Hart (2003) also conducted an empirical study of interidentity memory. They tested subjects with and without DID for their recall and recognition of emotionally neutral material. These authors found no difference between the groups. However, they noted that the results were specific to neutral material and that emotionally stimulating or traumatic stimuli might yield different results.

Dell (2001) performed an extensive review of the empirical literature which he combined with his own "rational-intuitive ideas" (p. 28) to arrive at an entirely new set of diagnostic criteria for DID. Further, he suggested an alternate system of organization for all the dissociative disorders for the next revision of the DSM. His rationale for the revision is that the present criteria lack reliability and content validity.

Gleaves, May, and Cardena (2001) conducted a review of the empirical evidence to determine the diagnostic validity of DID. They concluded that DID meets criteria for inclusion in the DSM IV (APA, 1994). However, they offered several suggestions to streamline the diagnosis process. For example, they suggested that criteria A and B be objectively measurable. They also recommended further research to determine why every child subjected to severe and sustained child abuse does not develop DID. Finally, they suggested research on the efficacy of various treatment modalities.

Lewis, Yeager, Swica, Pincus, and Lewis (1997) also addressed the question of etiology in their study of 12 murderers with DID. They objectively verified that 11 of the 12 subjects suffered severe and sustained abuse as

children. Further, using collateral sources of information, they also verified that all 12 cases exhibited symptomology of dissociation during childhood.

Putnam, Zahn, and Post (1990) studied the autonomic nervous system activity in subjects with MPD and control subjects who simulated alter-personality states. These researchers found differences in most of the MPD subjects as well as in some of the control subjects. The authors noted that their results support the diagnostic criterion that requires alter-personalities to be organized and discrete.

Miller and Triggiano (1992) published a comprehensive review of empirical studies that examine the psychophysiological differences between alter-personalities. These studies reported verifiable differences in galvanic skin response, autonomic nervous system activity, skin temperature, thyroid function, response to medication and more between alter-personalities. However, the authors noted that most, if not all, of these studies had methodological shortcomings and thus were inconclusive.

Watkins (1984) and Welburn (2003) pointed out the difficulty of differentially diagnosing DID from

psychopathy, schizophrenia, factitious disorder and malingering. Citing the case of convicted serial killer Kenneth Bianchi, Watkins (1984) asserted that MPD was the correct diagnosis based on careful analysis of Rorschach tests, handwriting samples, interviews and other evidence. Nonetheless, the court overruled his diagnosis. Welburn (2003) concluded that DID is distinguishable from schizophrenia and malingered or factitious dissociation if structured clinical interviews are used. Both of these studies indicated that the MPD and DID criteria need clarification and that objective measures of dissociation must be used to arrive at an accurate diagnosis.

In summary, the literature generally supports that the current diagnostic criteria for DID do meet professionally accepted standards for inclusion in the DSM IV (APA, 1994). However, researchers continue to challenge the criteria from many angles including objectivity, validity, reliability and measurability.

#### Legal Issues

As noted above, one's criminal responsibility and malingering are factors that present the courts with difficult decisions. Other legal factors relating to

cases of DID include the right to be Mirandized, testify on one's own behalf and plead guilty but not guilty by reason of insanity. Diagnostic issues of concern for the courts include malingering and iatrogenesis.

Behnke (1997) explained first, that a crime has been committed when a person commits a wrongful act and does so because of wrongful motivations. Second, he explained that the M'Naughten rule is the standard measure of legal insanity in the United States. The M'Naughten rule states that a person who is legally insane "[does] not know the nature, quality, or wrongfulness of his act" (p. 392). Presumably, it is possible for an alter-personality to commit a crime knowing fully the wrongfulness involved while the host personality has no knowledge of the act. This is the point that poses difficulty for the courts because the law gives little credence to a divided self. The consensus in legal forums is that each person has only one personality. In a later article on the controversy, Sinnott-Armstrong and Behnke (2000) conclude that unless a person is symptomatic at the time of commission, individuals with DID should be held accountable for their crimes. In other words, individuals

with DID are considered sane unless they are manifesting alter-personalities at the time of the crime.

Kennett and Matthews (2002) disagreed with Sinnott-Armstrong and Behnke (2000) and asserted the controversial opinion that DID is not a case of several people existing within one body, but rather it is a single person divided. Employing that opinion, they concluded that an individual with DID is a single, seriously mentally ill person and if they possess all of the diagnostic criteria for the disorder then they should not be held responsible for their actions.

Noonan (2000) emphasized that DID is increasing in numbers as a defense in criminal proceedings and therefore the need for reliable evaluation of responsibility is also increasing. He suggested that the disorder must be manifest at the time a crime is committed and that the crime is a relevant to the disorder. Further, he suggested that alter-identities may fail to meet legal sanity standards under the M'Naughten rule. Finally, he posited that the host personality must make an effort to right the wrong thus eliminating the possibility of the host benefiting from the crime. This approach clearly acknowledges the host and the alter-



personalities as separate agents and assigns them different legal responsibility.

Owens (1997) summarized legal cases from 1980 to 1996 that used MPD/DID as the mitigating factor for an insanity defense and noted that there was no consistent approach to defending or prosecuting these cases. He suggested the legal adoption of the host approach which "acknowledges separate personalities but places the emphasis on the host personality" (p. 138).

Coons (1991) conducted an analysis of 19 cases in which the defendants claimed a diagnosis of MPD; most of whom he believed were malingering. Additionally he reviewed the literature to assemble assessment guidelines for discerning between malingered versus genuine MPD. He suggested that the use of hypnosis for evaluation cannot produce genuine MPD, but instead can iatrogenically create symptoms that resemble it. He also suggested the use of collateral information, standardized tests of dissociation and awareness of amnesic features to make diagnoses.

Labott and Wallach (2002) studied the issue of malingering. Using subjects instructed to malingering and a control group instructed to respond honestly, they found

that the malingerers were able to mimic DID on Carlson and Putnam's (1993) Dissociative Experiences Scale II (as cited in Labott & Wallach, 2002). Therefore, they suggested that although the validity and reliability of the scale are high in clinical settings, the Dissociative Experiences Scale II may not be a conclusive test in forensic evaluations where an individual is motivated by some type of gain to obtain a diagnosis DID.

#### Attitudes, Beliefs and Skepticism toward Dissociative Identity Disorder

Several studies of attitudes, beliefs and skepticism have been conducted since the controversy began in the mid 1980s. Below is a discussion of each one. They are discussed in chronological order from earliest to latest. Most studies examined psychiatrists' and psychologists' attitudes except Dell's (1988) study that assessed "master's level therapists" (p. 528) and Hayes and Mitchell's (1994) study that explicitly assessed social workers' knowledge and skepticism.

Dell (1988) surveyed psychiatrists, psychologists and "master's degree therapists" (p. 528). It is difficult to determine how many members of this group were social workers. The participants in this study were

members of the International Society for the Study of Multiple Personality and Dissociation. The questionnaire asked if they had experienced skepticism from other professionals, what type of professionals the skeptics were, how often they encountered skepticism and how severe it was. A five-point likert scale was used to measure responses with mild, moderate, strong, severe and extreme as the choices. Seventy eight percent of respondents reported that they had encountered strong to extreme skepticism. This study utilized second-hand data in that skepticism was measured as it was perceived by proponents of DID rather than directly from skeptics or proponents. The sample and the data were thus intrinsically biased. In addition, the sample size was small (25 psychiatrists, 20 psychologists and 17 master's degree therapists) which limited the generalizability of the results.

Dunn et al. (1994) surveyed psychiatrists and psychologists to determine their belief in the existence of DID. From a possible 3600 respondents, 1,120 veterans administration professionals completed the questionnaire. Eighty percent of the sample indicated belief in DID and 97.5 percent believed that dissociative disorders are

genuine diagnostic entities. It is notable that the large number of non-respondents might have been skeptics. The results indicated an inverse relationship between belief in the disorder and age and years of experience. Pertinent to the present study is that among the professionals who indicated that they had worked with a client who was diagnosed with DID, 9.6 percent did not believe in the diagnosis at all and another 5.0 percent said they were not sure if they believe in it.

Hayes and Mitchell (1994) conducted three studies to determine professionals' knowledge of and skepticism toward MPD. The first was a pilot study to perfect the survey instrument that resulted in a questionnaire consisting of 11 skepticism items, six knowledge items and 13 distracter items.

Their second study surveyed a sample of social workers, psychiatrists and psychologists derived from membership rosters of professional organizations. The results indicated an inverse relationship between knowledge of and skepticism toward MPD. Interestingly, this relationship was stronger in psychiatrists than in social workers. Also noteworthy is that all three groups scored the same on the knowledge questions.

The third study was a replication of the second and subjects were collected in the same manner. The instrument too was the same save the addition of a case vignette from which respondents were asked to formulate a diagnosis. Again, skepticism and knowledge, and an accurate diagnosis were inversely related. Also found in was that psychiatrists are the most, and social workers the least, skeptical of the diagnosis.

These studies consistently showed that skepticism at a low or moderate level was present in about 75 to 80 percent of respondents. However, when extreme skepticism was noted, it was found more frequently in the psychiatrists. Social workers were the least skeptical.

McMinn and Wade (1995) studied the differences in beliefs about the prevalence of DID between Christian counselors and a control group. The Christian sample was randomly selected from among members of the American Association of Christian Counselors (AACC). This sample contained doctoral, master's, and subjects with no degree. The control group was randomly selected from the Counseling Psychology Division of the APA. This group contained those with doctorates and those without. The response rate was 57 percent for both groups. The results

indicated that Christian psychologists and the control group diagnosed DID at similar rates. Within the Christian group, master's level, lay counselors and psychologists also diagnosed DID with nearly equal frequency.

Cormier and Thelen (1998) conducted a survey to determine levels of skepticism toward DID. Their sample of 1000 was randomly derived from a master list of 31,818 American psychologists. The questionnaire contained 16 questions related to the validity, existence and etiology of DID. The results indicated that 79 percent of the respondents believed that it is a valid diagnosis, 92 percent believed it exists, and 84 percent believed DID originates from severe child abuse. The researchers suggested that the widely accepted notion of one self per person may cause clinicians to shy away from possible DID diagnoses. Further, the researchers suggested that professionals might not consult with other professionals when they have a diagnostic question regarding DID for fear of encountering ridicule or rejection.

Pope et al. (1999) studied the attitudes toward DID among board-certified American psychiatrists. Notable is that psychiatrists differed as to whether DID should be

included if the DSM IV (APA, 1994) were revised. Most (43 percent) believed that DID should be included with reservations. Further, the majority (51 percent) believed that DID was only partially supported by scientific evidence of validity. The results of this study were later merged with those of LeLonde et al. (2001) in order to form a comparison study between American and Canadian psychiatrists. The LeLonde et al. study is discussed below.

LeLonde et al. (2001) surveyed psychiatrists from Canada and the United States in two separate studies. They derived the Canadian sample by random selection from the Canadian Medical Directory and the American sample from the roster of board-certified psychiatrists. Response rates were about 80 percent for each study. The survey instrument had two items. The first item asked if the DSM were revised, how should it treat DID? The second item asked for an opinion about the status of the scientific evidence about DID. A four-point likert scale was used to measure the responses. The scale on item one ranged from "not to be included at all," "included with reservations," "included without reservations" to "no opinion" (p. 410). The results indicated that only 22

percent of the Canadians believe that DID should be included without reservations compared to 35 percent of Americans who made that selection. The scale on item two ranged from "little evidence of validity," "partial evidence of validity," "strong evidence of validity" to "no opinion" (p. 410). Eleven percent of the Canadians indicated that strong evidence exists to support the diagnosis compared to 21 percent of the Americans. Thus, this study showed that Americans are less skeptical of DID than Canadians.

#### Guiding Conceptualization Theories

Butler, Duran, Jasiukaitis, Koopman, and Spiegel (1996) suggested a diathesis-stress model of dissociation. This model is based on the hypothesis that individuals with a highly developed, innate ability to enter into a hypnotic state and who are exposed to severe and sustained abuses or trauma are likely candidates for developing dissociative disorders. The authors argued that the historic and successful use of hypnosis to treat dissociative disorders is evidence of the link between the two processes.



Dalenberg and Palesh (2004) argued that there is a connection between trauma and dissociation without suggesting the intermediary factor of hypnotizability. Based on a study of Russian and American college students, the authors found that the Russian subjects scored higher on measures of dissociation than did the Americans. However, they note that the Russians may have been less likely to divulge traumatic experiences because of cultural norms that differ from the American population.

Social psychology has a long and sometimes controversial history about the strength of the predictive link between attitudes and behavior. However, Baron and Byrne (2000) note that there is general theoretical agreement about when and how attitudes affect behavior, a summary of which is provided below. They noted that two factors modify *when* attitudes affect behavior including situational constraints and aspects including the origin, strength and specificity of the attitudes. They also noted factors that mitigate *how* attitudes affect behavior including intentions and willingness.

*Situational constraints* affect when we express our attitudes behaviorally. This is an issue of concern in the present study particularly if social workers are prevented by skeptical peers and other professionals from diagnosing, treating or testifying on behalf of clients who appear to them to have DID. Conversely, a social worker with a skeptical attitude toward DID may be influenced to diagnose and treat it by zealous peers or superiors.

When behavior corresponds with an attitude depends on three aspects of the attitude: its origin, strength and specificity. First, social psychologists assert that if the *origins* of an attitude are from direct experience it will be stronger and more predictive of behavior than if the attitude originated from indirect experience or the opinions of others. For example, a social worker who develops an attitude about DID based on direct experience with patients who have the disorder is likely to have a stronger attitude (positive or negative) than workers who base their attitude on the opinions of others.

The *strength* of an attitude is one of the most important factors in the attitude-behavior link. It is dependent on the intensity and extremity of the attitude.

Additionally, how important the attitude is to an individual - how invested the holder of the attitude is in it - also determines strength. Other factors in attitude strength are the attitude holder's level of knowledge and the relevance of the topic to the holder.

Attitude strength is a key factor contributing to the controversy over DID. Extremists exist on both sides of the controversy with skeptical non-clinical researchers on one side and clinical proponents on the other. As with many hotly debated controversies, the truth of the matter probably lies somewhere between the extremes and might be properly settled by individuals who have little or no stake in the outcome.

The predictive link between attitude and behavior is enhanced by the *specificity* of the relationship. For example a worker who believes DID is very common and under diagnosed is more likely to diagnose it than a clinician who maintains an open mind about all diagnoses and considers a client's clinical symptoms objectively before making or not making any diagnosis.

How attitudes affect behavior is based on two factors: intentions and willingness. *Intentions* are considered the single best predictor of behavior and are

illustrated in two theories. Ajzen and Fishbein's 1980 theory of planned behavior (as cited in Baron & Byrne, 2000) suggests that engaging in a behavior is the result of one's attitudes combined with thoughtful foresight and pre-planning. However, in spontaneous situations when one is not able to plan, the attitude-to-behavior process model proposed by Fazio in 1989 (as cited in Baron & Byrne, 2000) suggests that an event triggers an attitude that subsequently combines with social norms to determine one's *willingness* to engage in a particular behavior. In the case of a social worker, circumstances leading to planned or spontaneous behavior can occur. For example, even when a worker has no skepticism toward DID and *intends* to exhibit pro-DID behavior, she may only be *willing* to present a skeptical attitude while in a courtroom full of skeptics and under questioning from an aggressive prosecuting attorney.

### Summary

The DSM criteria for DID were discussed. Several studies and empirical reviews that examine the DSM criteria were looked at. Studies that attempt to verify alter-personalities via psychophysiological evidence were

examined. Legal issues including responsibility, Miranda rights, testifying on one's own behalf, and the plea of insanity were also reviewed. Several studies regarding professional mental health care providers' attitudes, beliefs and skepticism were discussed. Finally, theories of dissociation and the predictive link between attitudes and behavior were examined.

## CHAPTER THREE

### METHODS

#### Introduction

The purpose of this study was to determine the levels of knowledge of and skepticism toward DID that forensic social workers have. The relationship between the dependent variables of knowledge and skepticism were assessed. Further, the relationships between knowledge of and skepticism toward DID and several independent variables were analyzed. This chapter describes the study design, sampling techniques, data collection methods, measuring instrument, procedures, protection of human subjects and data analysis.

#### Study Design

This study replicated a previous skepticism and knowledge study of DID by Hayes and Mitchell (1994). However, this study focused only on forensic social workers' skepticism and knowledge. In particular, this study employed questionnaires to explore the relationships between the dependent variables (Appendix A) of skepticism toward and knowledge of DID and several independent variables (Appendix C) including demographic

items (age, gender and ethnicity) and professional practice items (profession, highest educational degree, number of certificates and credentials held, years in practice, practice setting, theoretical orientation, number of DID seminars and conferences attended, number of DID diagnoses made and number of DID cases treated).

This study employed a quantitative, mail-out survey design which allowed for rapid collection of data from a nationwide sample within the time constraints intrinsic in a thesis study. A limitation of this study was that the sample only included self-identified forensic social workers who are members of the NOFSW. This may not be a representative sample of all forensic social workers in America and therefore, may limit the generalizability of the results.

It was hypothesized that an inverse relationship would be found between skepticism toward, and knowledge of DID. It was also expected that older practitioners would be more skeptical and less knowledgeable than those who are younger. Similarly, individuals in practice longer were expected to be more skeptical and less knowledgeable than those who were early in their careers. Finally, it was hypothesized that higher levels of

skepticism and lower levels of knowledge would be found in practitioners with a cognitive and/or behavioral theoretical orientation compared with practitioners who have other theoretical orientations.

### Sampling

Participants were recruited from the National Organization of Forensic Social Workers (NOFSW) membership directory. NOFSW is a professional association which included 422 individuals at the time this study was conducted. Survey packets were mailed to every member. This population was selected in an effort to obtain a relatively large data set that represented the many types of forensic social workers throughout the United States.

Of the 422 survey packets that were mailed, 26 were returned because they were undeliverable as addressed. One was eliminated because it was mailed to the author of the present study. Two were returned uncompleted only to enter the raffle drawing. One was returned uncompleted because the intended recipient had died. One was returned because the intended participant noted that he had not practiced in the field for a while and was therefore unqualified to participate. Two were eliminated because



they were returned after the data had already been analyzed. One hundred ninety three surveys were not returned at all. Thus, 196 of 389 possible completed surveys were utilized in this study, which represented a response rate of 50.39 percent.

The strength in this quantitative method of data collection was that it allowed for speedy and objective analysis of the results. A limitation, however, was that respondents were restricted to specific responses which may have eliminated important variations and nuances from their responses which could have been obtained from a qualitative method of data collection.

#### Data Collection and Instruments

Data collected included information about the dependent variables of skepticism toward and knowledge of DID using a 32-item questionnaire (Appendix A). The skepticism scale included 11 items, the knowledge scale included 5 items and the remaining 16 items were distracters. The distracter items were about psychopathy, antisocial personality disorder and schizophrenia.

Independent variable data were gleaned from a 12-item questionnaire (Appendix C) that included

demographic items (age, gender and ethnicity) and professional practice items (profession, highest educational degree earned, number of specialist certificates/credentials held, years in practice, practice setting, theoretical orientation, number of DID seminars/conferences attended, number of DID diagnoses made and number of DID cases treated).

The questionnaire employed in this study (Appendix A) was adapted from the knowledge and skepticism scales created by Hayes and Mitchell (1994). These researchers first conducted a pilot study from which they assessed the validity and reliability of their instrument. As a result of this process, some items were eliminated because they negatively affected the internal consistency, had poor correlations with their respective scales, or were confusing or offensive. The authors did not assess this instrument for cultural sensitivity. This process rendered an instrument with 16 items upon which participants rated their level of agreement or disagreement on five point Likert-scales containing the response options of strongly disagree, disagree, unsure, agree and strongly agree.

The skepticism and knowledge data collected for the present study utilized the same Likert-scale, ordinal method of measurement rendering a five-item knowledge scale with a minimum possible score of five and a maximum possible score of 25. The eleven-item skepticism scale had a minimum possible score of 11 and a maximum possible score of 55.

Since the Hayes and Mitchell study used the diagnostic criteria for MPD from the DSM III (APA, 1980) to measure participants' level of knowledge, the knowledge scale for the present study was updated to assure that it was compatible with the DSM IV (APA, 1994) criteria for DID.

### Procedures

The names and addresses of the participants were obtained from the May 2004 NOFSW membership directory. Permission was obtained via e-mail correspondence from the NOFSW president to use the directory for the purpose of the present study (Appendix D). On February 12, 2005, the 422 potential participants were mailed a cover letter that included informed consent and debriefing statements (Appendix B), the survey instrument (Appendices A & C)

and a pre-addressed postage-paid envelope in which participants could return their survey and raffle ticket.

To encourage responses, the survey packet also included a raffle entry ticket which, if returned (with or without a completed survey), made them eligible to win one of three 50-dollar gift certificates to the National Association of Social Workers (NASW) Press. The returned raffle entry tickets were kept separate from the returned questionnaires to protect the anonymity of the respondents. A blind grab-bag method of selection was used to determine the three raffle-prize winners whose names were announced in the NOFSW newsletter after the research was completed in June 2005. To further encourage responses, a follow-up reminder card was mailed to all potential participants 11 days after the original mailing on February 23, 2005.

#### Protection of Human Subjects

The cover letter that accompanied the survey instrument included informed consent and debriefing statements (Appendix B). Potential participants were informed that this study and the survey instrument had been reviewed and approved by the Department of social

Work Sub-Committee of the Institutional Review Board of California State University, San Bernardino. Participants were also informed of this researcher's identity, that the project was supervised by Dr. Rosemary McCaslin, and that permission to use the NOFSW membership for this research was obtained from that organization's president, Catherine Heffernan.

A brief description of the nature and purpose of the study, and notification of the voluntary nature of participation was provided. Participants' names were not placed on the questionnaires or associated with their responses in any way.

Finally, respondents were provided with debriefing information including contact information for the project supervisor should they have any questions or concerns whatsoever. No risks to the respondents were expected.

#### Data Analysis

In the interest of increasing statistical power and reliability, and decreasing the probability of sampling errors, this study utilized a large sample consisting of the entire membership of the NOFSW, which yielded a net sample size of 196.

Quantitative data analysis was employed to assess the relationship(s) between the dependent variables (knowledge and skepticism) and the independent variables (age, gender, ethnicity, profession, highest educational degree earned, number of specialist certificates and/or credentials held, years in practice, practice setting, theoretical orientation, number of DID seminars and conferences attended, number of DID diagnoses made and number of DID cases treated). Univariate and bivariate data analysis were employed to examine the relationships between the above-mentioned variables was assessed using various inferential statistics.

Knowledge of and skepticism toward DID were tested on a scale level of measurement using a total score derived from five point Likert-scales rank-ordered such that 1 = strongly disagree, 2 = disagree, 3 = unsure, 4 = agree, and 5 = strongly agree. The possible range of total scores on the five-item knowledge scale was five to 25. The possible range of total scores on the 11-item skepticism scale was 11 to 66.

Age, number of specialist certificates and/or credentials held, years in practice, number of DID seminars and/or conferences attended, number of DID

diagnoses made and number of DID cases treated were analyzed on a scale level of measurement. If a respondent left the aforementioned items blank, they were processed as missing data rather than zero. Gender, ethnicity, profession, highest educational degree earned, practice setting and theoretical orientation were analyzed on a nominal level of measurement.

Frequency and descriptive statistics including frequency distribution, measures of central tendency and variability were used to organize the data and provide an overview of the characteristics of the sample. Inferential statistics were then employed to assess the relationships between variables.

The relationships between knowledge and skepticism, and the independent variables that utilize nominal levels of measurement were analyzed using t-test analyses. Correlation analyses were employed to examine the relationships between variables with ordinal and scale levels of measurement.

### Summary

This chapter discussed the methods that were employed in this study.

A detailed description of the quantitative survey design of this exploratory study was provided. The sample frame was described as the complete membership of the NOFSW and the rationale for selecting that population was given.

The survey instrument was described and the procedures used to assess its validity, reliability, and cultural sensitivity were examined.

The procedure for collecting data was outlined and a timetable of the research process was provided. Measures that were used to protect human subjects were also noted.

Finally, the types of statistical analyses that were applied to the dependent variables (knowledge and skepticism) and the independent variables (demographics and professional practice items) were discussed.



## CHAPTER FOUR

### RESULTS

Demographic and professional practice characteristics of the sample are presented utilizing frequency and descriptive statistics. Also provided are frequency and descriptive data regarding the participants' responses to each item on the knowledge and skepticism scales. Correlations between the levels of knowledge and skepticism are given as well correlations between those items and the demographic characteristics of the participants.

#### Presentation of the Findings

##### Demographic Variable Frequencies

Ninety-eight percent of the respondents indicated their age. The mean was 44.96 years ( $SD = 11.99$ ). The oldest was 82 and the youngest was 21 ( $R = 61$ ).

Ninety-nine percent of the respondents indicated their gender. More than two-thirds were female (68.0%).

Ninety-seven percent of the participants indicated their ethnicity. The majority identified as non-Hispanic White (86.9%) followed by African Americans (8.4%), Hispanics (3.1%) and other (1.6%).

### Professional Practice Variable Frequencies

All but one respondent indicated their profession (99.5%). Social work was predominant (85.6%); followed by administrator (3.6%), attorney/legal service provider (3.1%) and other (7.6%). Ninety nine percent of the subjects indicated the level of their highest degree. Most indicated a master's (79.4%); followed by doctoral/post-doctoral/juris-doctorate (13.9%) and bachelors (6.7%).

Seventy-six percent ( $N = 196$ ,  $n = 149$ ) of the respondents indicated the number of specialist certificates and/or credentials they hold. The mean was 1.87 ( $SD = 1.17$ ). Most held one (50.3%), two (28.2%) or three (12.8%); followed by four (4.7%), five (1.3%) or six or more (2.7%). Ninety-eight percent of the subjects indicated how many years they have practiced in their profession. The mean was 15.25 ( $SD = 11.12$ ). The most was 60 and the least was zero ( $R = 60$ ).

The response rate for the practice-setting item was 80.1 percent ( $N = 196$ ,  $n = 157$ ). Public mental health was predominant (31.2%); followed by private mental health (26.8%), court/law firm (14.0%), community agency (12.1%), prison/jail/police (5.1%), public welfare

(3.8%), school (2.5%), agency administration (1.9%), probation/parole (1.3%) and medical health (1.2%). The response rate for the theoretical orientation item was 84.7 percent ( $N = 196$ ,  $n = 166$ ). The leading orientations with nearly equal rates of selection were eclectic (38.6%) and cognitive-behavioral (38.0%); followed by psychoanalytic/psychodynamic (9.6%) and family systems (9.0%) which also had similar rates. Humanistic/existential (4.2%) and multicultural (0.6%) were the least common.

Slightly more than two-thirds (70.4%) ( $N = 196$ ,  $n = 138$ ) of the participants indicated how many DID seminars and conferences they had attended. The mean was 1.89 ( $SD = 3.61$ ). The most was 30 and the least was zero ( $R = 30$ ). About three fifths of the sample indicated how many DID cases they had diagnosed (59.2%) ( $N = 196$ ,  $n = 116$ ) and treated (60.2%) ( $N = 196$ ,  $n = 118$ ). The mean number of diagnoses made was 2.19 ( $SD = 6.79$ ). The highest was 50 and the lowest was zero ( $R = 50$ ). The mean number of cases treated was 3.63 ( $SD = 12.64$ ). The most was 100 and the least was zero ( $R = 100$ ).

### Knowledge Scale Analyses

A Chronbach's Alpha coefficient analysis of the original five-item knowledge scale yielded a somewhat low level of reliability ( $\alpha = .412$ ). To improve the reliability of that scale, the "DID is an Axis II disorder in the DSM-IV-TR" item was excluded. The resulting four-item scale yielded a higher Chronbach's Alpha coefficient ( $\alpha = .493$ ) and was used to analyze the results.

Ninety-eight percent of the surveys yielded viable knowledge scale scores. The range of possible scores on the knowledge scale was four to 20 ( $R = 16$ ). The participants' scores ranged from a low of 10 to a high of 20 ( $R = 10$ ). For conceptualization purposes, the scores were compressed into the following categories: "very low" = 4-8, "low" = 9-12, "high" = 13-16 and "very high" = 17-20. The participants' mean level of knowledge was 14.76 ( $SD = 2.06$ ), which falls into the "high" category. The "high" category was predominant (70.8%); followed by "very high" (15.7%) and "low" (13.5%). No participants had a "very low" level of knowledge.

Table 1 illustrates the frequency of participants' responses to each item on the level of knowledge scale,

expressed as percentages. Also provided are the mean scores for each item, and the correlation between each item and the total levels of knowledge and skepticism scores.

Table 1. Knowledge Items with Percentages and Means, and Correlations with Knowledge and Skepticism Scores

Scale Item	V%	L%	U%	H%	VH%	M	r(K)	r(S)
Major trauma is a contributing factor to development of DID	.5	3.1	10.2	54.1	32.1	4.14	.61**	-.29**
Documented cases of DID have increased over the past two decades	.5	3.6	42.9	47.4	5.6	3.54	.57**	-.09
DID is diagnosed more frequently in females than in males	.5	4.7	23.8	51.8	19.2	3.84	.65**	.01
The onset of DID is almost invariably in childhood	3.1	21.9	30.7	35.9	8.3	3.24	.69**	-.26**
VL = Very Low Knowledge, L = Low Knowledge, U = Unsure, H = High Knowledge, VH = Very High Knowledge * = $p < 0.05$ (2-tailed) ** = $p < 0.01$ (2-tailed) r(K) = Correlation with knowledge scale r(S) = Correlation with skepticism scale								

Table 2 illustrates the correlations between the total knowledge and skepticism scores, and the

independent variables that were assessed on ordinal and scale levels of measurement.

Table 2. Correlations between Ordinal and Scale Independent Variables, and Knowledge and Skepticism Scores

Variable	1	2	3	4	5	6	7	8
1. Age	-	.17*	.79**	.22**	.25**	.21**	.04	-.10
2. Certificates & credentials		-	.17*	.22*	.48**	.26*	.18*	-.28**
3. Years practice			-	.30**	.29**	.28**	.01	-.06
4. Seminars & conferences				-	.67**	.67**	.05	-.06
5. Cases diagnosed					-	.83**	.09	-.22*
6. Cases treated						-	.11	-.04
7. Knowledge score							-	-.26**
8. Skepticism score								-
* = $p < 0.05$ (2-tailed)								
** = $p < 0.01$ (2-tailed)								

A strong negative correlation was found between levels of knowledge and skepticism ( $r = -.26$ ,  $p = .00$ ). No significant correlations were found between age and years in practice, and levels of knowledge or skepticism. However, non-significant correlations indicated that older individuals may have higher levels of knowledge and lower levels of skepticism as might those with more years in practice.

Regarding independent variables assessed with a nominal level of measurement, no significant effect on level of knowledge scores was noted with participants' gender, level of degree, practice setting or theoretical orientation.

To analyze the effect of ethnicity on level of knowledge scores, ethnicity categories were compressed into "non-Hispanic White" (84.9%) and "other" (15.1%). Individuals who identified as "non-Hispanic White" had a higher mean level of knowledge score ( $M = 14.94$ ) than those who identified as "other" ( $M = 13.72$ ) ( $t = 2.99$ ,  $df = 190$ ,  $p = .003$ ).

To analyze the effect of participants' profession on level of knowledge scores, profession categories were compressed into "social worker" (84.9%) and "other" (15.1%). Individuals who identified as "social worker" had a higher mean knowledge score ( $M = 14.88$ ) than those who identified as "other" ( $M = 14.07$ ) yielding a nearly significant result ( $t = 1.97$ ,  $df = 190$ ,  $p = .051$ ).

#### Skepticism Scale Analyses

A Chronbach's Alpha coefficient analysis of the skepticism scale yielded an acceptable level of

reliability ( $\alpha = .770$ ). The entire eleven-item scale was used to analyze the results.

Ninety-five percent of the surveys yielded viable skepticism scale scores. The range of possible scores on the skepticism scale was 11 to 55 ( $R = 44$ ). For conceptualization purposes, the scores were compressed into the following categories: "very low" = 11-22, "low" = 23-33, "high" = 34-44 and "very high" = 45-55. The participants' mean level of skepticism was 29.26 ( $SD = 5.86$ ), which falls into the "low" category. The "low" category was predominant (67.2%); followed by "high" (21.1%) and "very low" (11.7%). No participants had "very high" levels of skepticism.

Table 3 illustrates the frequency of participants' responses to each item on the level of skepticism scale, expressed as percentages. Also provided on Table 3 are the mean scores for each item and the correlation between each item and the total levels of knowledge and skepticism scores.



Table 3. Skepticism Items with Percentages and Means and Correlations with Skepticism and Knowledge Scores

Scale Item	VL%	L%	U%	H%	VH%	M	r(K)	r(S)
DID can be created in counseling psychotherapy	10.2	31.1	30.6	25.5	2.6	2.79	-.03	.49**
DID is a misdiagnosis of schizophrenia	21.9	50.5	18.4	8.2	1.0	2.16	-.07	.25**
DID is largely an excuse used to avoid personal responsibility	24.5	51.5	16.3	7.1	.5	2.08	-.28**	.53**
I would not diagnose someone as having DID	14.5	49.2	22.3	12.4	1.6	2.37	-.21**	.68**
DID is extremely rare	3.6	26.4	27.5	29.0	13.5	3.22	-.01	.64**
People can successfully fake DID	5.7	26.9	24.4	40.4	2.6	3.07	-.05	.50**
Symptoms of DID can be explained by and diagnosed as another disorder	3.6	23.4	24.0	42.7	6.3	3.24	-.02	.47**
DID does not exist	32.3	47.9	15.6	3.1	1.0	1.93	-.22**	.64**
The existence of DID has been demonstrated beyond a reasonable doubt	11.2	34.7	20.4	29.1	4.6	2.81	-.26**	.63**
DID is under-diagnosed	3.1	16.1	45.1	27.5	8.3	3.22	-.22	.64**
More funding should be devoted to research on DID	11.7	48.0	26.0	12.8	1.5	2.44	-.25**	.59**
VL = Very Low Skepticism, L = Low Skepticism, U = Unsure, H = High Skepticism, VH = Very High Skepticism * = $p < 0.05$ (2-tailed) ** = $p < 0.01$ (2-tailed) r(K) = Correlation with knowledge scale r(S) = Correlation with skepticism scale								

## Summary

The sample size was 196 and consisted primarily of master's degree level social workers with one or two specialist certificates and/or credentials and 15 years in practice. The participants' mean age was 45 and the predominant ethnicity was non-Hispanic White. Their leading practice setting was public mental health. Most identified their theoretical orientation as eclectic or cognitive-behavioral. The participants attended a mean number of one to two DID seminars and/or conferences, diagnosed two and treated four cases of DID.

A negative correlation was found between participants' levels of knowledge and skepticism. Most participants scored relatively high on knowledge and low on skepticism with fewer, if any in the very high and very low categories. Increased age and years in practice did not correlate with lower knowledge and higher skepticism. Ethnicity and profession were found to have an effect on levels of knowledge and skepticism but theoretical orientation did not.

## CHAPTER FIVE

### DISCUSSION

#### Discussion

The hypothesis that levels of knowledge and skepticism would be inversely related was supported by the findings of this study. This finding aligns with a previous study by Cormier and Thelen (1998) in which doctoral level psychologists indicated that positive attitudes about DID correlated with familiarity with DID research literature. The Hayes and Mitchell (1994) study of psychiatrists', psychologists', and social workers' skepticism toward DID also found an inverse relationship between knowledge and skepticism.

The consistency of the findings of an inverse relationship between levels of knowledge and skepticism across studies that span more than a decade indicates that the phenomenon is valid and if levels of knowledge about DID were increased skepticism would decrease.

Contrary to the findings of Cormier and Thelen (1998), and Hayes and Mitchell (1994), this study did not find support for the hypothesis that there would be a significant correlation between more years an individual

has been in practice, and lower knowledge and higher skepticism.

The explanation for the difference between this and the Cormier and Thelen (1998) study may be that the latter study examined psychologists and this one examined forensic social workers. Inferring any difference beyond the intrinsic differences in professions is difficult. However, the Hayes and Mitchell (1994) study assessed social workers, making a comparison between the two studies reasonable.

One explanation is that the present study examined forensic social workers; a subgroup of the population used in the Hayes and Mitchell (1994) study. There may be elements intrinsic in forensic work that lead workers to be more knowledgeable of, and less skeptical toward DID no matter how long they have been in practice. For example, a diagnosis of DID in a death penalty case can mean life versus death whereas in clinical work outside of the legal arena a diagnosis might do more harm than good by stigmatizing an individual. Another possibility is that forensic social workers may encounter more severe mental illness more often thus mitigating low knowledge and high skepticism with familiarity.

Another possible explanation of why workers with more years in practice were not less knowledgeable and more skeptical in the present study is that a decade has passed since the Hayes and Mitchell (1994) study and workers who were relatively young at that time (hence, more knowledgeable and less skeptical) held on to their views through time. If this explanation were valid, then one would assume that knowledge has increased and skepticism decreased over time and across professions.

The hypothesis that forensic social workers with cognitive and/or behavioral theoretical orientations would be less knowledgeable and more skeptical than those who endorse other orientations was not supported in the present study. Hayes and Mitchell (1994) discovered that participants with a humanistic orientation had lower skepticism than those with other orientations. Cormier and Thelen (1998) found that those who endorsed a dynamic orientation had lower skepticism than those with a cognitive-behavioral orientation.

Strong correlations indicated that workers who had more specialist credentials and certificates had significantly higher levels of knowledge and lower levels of skepticism than those with fewer. This is interesting

because the vast majority of specialist credentials and certificates that participants listed had nothing to do with DID. Most were state licenses, sex-offender treatment certificates and certificates of competency in crisis intervention and so on. One implication is that individuals who vigorously pursue education in any area of specialization tend to be more knowledgeable and less skeptical about DID.

On the item that most directly assessed belief in the existence of DID, the workers who participated in this study indicated overwhelming belief that it does. The item stated, "DID does not exist" and 32 percent strongly disagreed, 48 percent disagreed and 15 percent were unsure.

However, the other existence item, which stated that "the existence of DID has been demonstrated beyond a reasonable doubt" garnered less support. Only 11 percent strongly agreed and 35 percent agreed with that statement while 20 percent were unsure. A full 34 percent agreed that the disorder may not exist. Interestingly, the conflicting results on these two existence items suggest that a controversy over DID not only exists between professionals, but within them as well.

## Limitations

Several characteristics of the survey instrument may have had a negative impact on the outcome of this study. For example, the questionnaire was rather long. Additionally, many participants focused strongly on the distracter items that pertained to psychopathy as was noted by their comments which ranged from a few handwritten words to lengthy, typewritten dissertations.

The physical layout of the survey may also have discouraged full participation. The instrument was printed on both sides of two pages and several participants appeared to overlook the reverse sides.

The items pertaining to the number of seminars/conferences, DID diagnoses and DID cases treated lacked instructions to fill in all spaces even if the response was zero resulting in many that were processed as missing data. Additionally, these items may have overwhelmed participants and should have specified a limited time period such as the past year.

Finally, the exploratory design of this study and the level of statistical analyses performed do not allow for inferences about the cause behind the correlations that were discovered.

## Recommendations for Social Work Practice, Policy and Research

This study reiterated the findings of previous researchers that an inverse relationship exists between knowledge of and skepticism toward DID. The consistency of this finding across studies suggests that the energy devoted to the controversy over DID might be well spent on education and research about the disorder as well as the dissociative phenomena in general.

The cause of ambiguity in mental health professionals' skepticism toward the existence of DID is an area in need of further research. As this and previous studies have illuminated, the doubts about the existence of DID not only occur between professionals, but may occur within them as well. Is our core belief that one person is allowed just one state of being so engrained that it causes us to contradict our own opinions? Is the concept of a divided self so threatening that it causes us to become the thing we fear? These questions and more are worthy of further research.

Nearly 40 percent of social workers in the present study indicated that their theoretical orientation was "eclectic." Such a non-committal selection by such an



overwhelming number of respondents may be worthy of further clarification and study. What exactly does it mean to have an eclectic orientation? Does it mean you do not have any particular way of perceiving the world around you or the people in it?

Other mental health professions such as psychiatry and psychology encourage practitioners to adopt an orientation from which they can conceptualize a case and arrive at an evidence-based, logical and orderly course of treatment. The issue is not to adopt *the* correct theory, but rather to adopt one that resonates with how one perceives herself and others in order to deliver efficient and effective service to clients.

Post hoc assessment of the data gathered from the distracter items in the questionnaire illuminated that an additional controversy may be in play over the construct of psychopathy. Investigation of mental health professionals' knowledge of and skepticism toward that topic may also be fruitful. This is an important area of study in forensic settings because although psychopathy is not included in the current DSM IV TR (APA, 1994), forensically committed individuals are routinely "diagnosed," labeled and (not) treated as psychopaths.

## Conclusions

This study suggests that the controversy over the existence of DID remains in play, making the debate over a quarter of a century old. The findings of past research that indicate an inverse relationship between knowledge of and skepticism toward DID were reiterated which confirmed hypothesis a) In contrast to social workers in prior studies, forensic social workers with more years in practice did not have lower levels of knowledge and higher levels of skepticism than those who are younger which refuted hypothesis b) Finally, contrary to hypothesis c) practitioners with psychodynamic and/or psychoanalytic theoretical orientations were not more knowledgeable or less skeptical than those with other theoretical orientations.

APPENDIX A  
QUESTIONNAIRE

### Questions about Mental Disorders:

Using the following scale, place the number that corresponds with your level of agreement or disagreement in the blank that precedes each statement.

1 = Strongly Disagree 2 = Disagree 3 = Unsure 4 = Agree 5 = Strongly Agree

1. \_\_\_\_\_ The existence of dissociative identity disorder has been demonstrated beyond reasonable doubt.
2. \_\_\_\_\_ Psychopathy does not exist.
3. \_\_\_\_\_ Dissociative identity disorder is under-diagnosed.
4. \_\_\_\_\_ Symptoms of antisocial personality disorder can be explained by and diagnosed as another disorder.
5. \_\_\_\_\_ Dissociative identity disorder can be created in counseling/psychotherapy.
6. \_\_\_\_\_ The onset of psychopathy is almost invariably in childhood.
7. \_\_\_\_\_ Dissociative identity disorder is a misdiagnosis of schizophrenia.
8. \_\_\_\_\_ People can successfully fake antisocial personality disorder.
9. \_\_\_\_\_ Antisocial personality disorder is largely an excuse used to avoid personal responsibility.
10. \_\_\_\_\_ Major trauma is a contributing factor to the development of dissociative identity disorder.
11. \_\_\_\_\_ Psychopathy is extremely rare.
12. \_\_\_\_\_ More funding should be devoted to research on dissociative identity disorder.
13. \_\_\_\_\_ Antisocial personality disorder is diagnosed more frequently in females than in males.
14. \_\_\_\_\_ Documented cases of dissociative identity disorder have increased over the past two decades.
15. \_\_\_\_\_ I would not diagnose someone as having psychopathy.
16. \_\_\_\_\_ Dissociative identity disorder is an Axis II disorder in the DSM-IV-TR.
17. \_\_\_\_\_ Dissociative identity disorder is largely an excuse used to avoid personal responsibility.
18. \_\_\_\_\_ Psychopathy is an Axis II disorder in the DSM-IV-TR.
19. \_\_\_\_\_ I would not diagnose someone as having dissociative identity disorder.
20. \_\_\_\_\_ Documented cases of antisocial personality disorder have increased over the past two decades.

21. \_\_\_\_\_ Dissociative identity disorder is diagnosed more frequently in females than in males.
22. \_\_\_\_\_ More funding should be devoted to research on psychopathy.
23. \_\_\_\_\_ Dissociative identity disorder is extremely rare.
24. \_\_\_\_\_ Major trauma is a contributing factor to the development of antisocial personality disorder.
25. \_\_\_\_\_ People can successfully fake dissociative identity disorder.
26. \_\_\_\_\_ Psychopathy is a misdiagnosis of antisocial personality disorder.
27. \_\_\_\_\_ The onset of dissociative identity disorder is almost invariably in childhood.
28. \_\_\_\_\_ Antisocial personality disorder can be created in counseling/psychotherapy.
29. \_\_\_\_\_ Symptoms of dissociative identity disorder can be explained by and diagnosed as another disorder.
30. \_\_\_\_\_ Psychopathy is under-diagnosed.
31. \_\_\_\_\_ Dissociative identity disorder does not exist.
32. \_\_\_\_\_ The existence of antisocial personality disorder has been demonstrated beyond reasonable doubt.

APPENDIX B

INFORMED CONSENT/DEBRIEFING STATEMENT

## INFORMED CONSENT/DEBRIEFING STATEMENT

Amy Lee Consolati, MSW Graduate Student  
California State University, San Bernardino  
19815 Big Pines Highway  
Valyermo, CA 93563

February 3, 2005

Dear NOFSW Member,

I am writing to ask you to help me fulfill my MSW research requirements by completing and returning the enclosed questionnaire. You have been selected to participate in this study because a national sample of forensic social workers is desired and NOFSW members are ideal for this purpose. Your participation is voluntary and whether or not you participate, you may return the enclosed raffle entry ticket to become eligible to win one of three 50-dollar NASW Press gift certificates. I will announce the winners in the NOFSW newsletter after the research is completed in June of 2005.

This study examines forensic social workers' thoughts about certain mental disorders. The questionnaire consists of 32 disorder, three demographic and nine professional practice questions. Because similar research is missing from the social work literature, it is hoped that the current study will begin to fill the gap. This is a Master's Degree thesis study and the final product will be available in the California State University, San Bernardino Pfau Library.

The Social Work Institutional Review Board Subcommittee of California State University, San Bernardino has reviewed and approved this study. My thesis advisor, Dr. Rosemary McCaslin, supervises this work. Catherine Heffernan, president of NOFSW, approved the use of the NOFSW membership mailing list for this purpose.

In addition to this questionnaire, I will send you a follow-up reminder card in about one week. No other contact will be made with you unless you request it. You will not be asked to do anything other than spend about 10-15 minutes completing this questionnaire.

Your anonymity is assured in this study. Your responses to the questionnaire will be statistically analyzed as part of group data and will never be associated with your name or other identifying information. The number on the back of your questionnaire is for data organization purposes and is in no way associated with you.

It is not anticipated that you will incur any long- or short-term discomfort or significant inconvenience by participating in this study. However, if at any time you have questions or concerns about it please contact Dr. Rosemary McCaslin at 909.880.5507 or [rmccasli@csusb.edu](mailto:rmccasli@csusb.edu).

I have provided a return postage paid envelope for your convenience. Thank you, in advance, for your participation in this research project.

Amy Lee Consolati  
MSW Graduate Student  
California State University, San Bernardino

APPENDIX C

DEMOGRAPHICS/PROFESSIONAL PRACTICE



Demographic Questions:

33. What is your age (fill in blank)?

\_\_\_\_\_

34. What is your gender (circle one)?

1. Female

2. Male

3. Other: \_\_\_\_\_

35. What is your ethnicity (circle one)?

1. African American

2. Hispanic

3. Non-Hispanic White

4. Asian/Pacific Islander

5. Native American

6. Other: \_\_\_\_\_

Professional Practice Questions

36. What is your profession (circle one)?

1. Social Worker

2. Clinical Psychologist

3. Counseling Psychologist

4. Psychiatrist

5. Other: \_\_\_\_\_

37. What is the highest degree you have earned (fill in blank)?

\_\_\_\_\_

38. What specialist certificates/credentials do you hold (fill in blank)?

\_\_\_\_\_

39. How many years have you practiced in the above profession (fill in blank)?

\_\_\_\_\_

40. What is your primary work setting (circle one)?

1. Private practice
2. Public mental health
3. Private mental health
4. School
5. Public medical health
6. Private medical health
7. Community agency
8. Public welfare
9. Agency administration
10. Policy and planning
11. Other: \_\_\_\_\_

41. What is your theoretical orientation (circle one)?

1. Psychoanalytic/psychodynamic
2. Humanistic/existential
3. Cognitive behavioral
4. Family systems
5. Feminist
6. Multicultural
7. Eclectic
8. Other: \_\_\_\_\_

42. How many seminars/conferences have you attended, in which you learned about the following topics (place a number in all blanks that apply)?

1. \_\_\_\_\_ Psychopathy
2. \_\_\_\_\_ Dissociative identity disorder
3. \_\_\_\_\_ Schizophrenia
4. \_\_\_\_\_ Antisocial personality disorder

43. How many individuals have you diagnosed with the following disorders (place a number in all blanks that apply)?

1. \_\_\_\_\_ Psychopathy
2. \_\_\_\_\_ Dissociative identity disorder
3. \_\_\_\_\_ Schizophrenia
4. \_\_\_\_\_ Antisocial personality disorder

44. How many individuals with the following diagnoses have you treated (place a number in all blanks that apply)?

1. \_\_\_\_\_ Psychopathy
2. \_\_\_\_\_ Dissociative identity disorder
3. \_\_\_\_\_ Schizophrenia
4. \_\_\_\_\_ Antisocial personality disorder

APPENDIX D

LETTER OF CONSENT FROM NATIONAL ORGANIZATION  
OF FORENSIC SOCIAL WORKERS

Amy -

I apologize for not checking our membership directory to see that you are a member. I have no problem with you accessing the members to do research. I don't know that we have mailing labels available however. You can check with Jerry Krone ([gfrkrone@comcast.net](mailto:gfrkrone@comcast.net)) our Executive Secretary.

Good luck with your research.

Katie

----- Original Message -----

**From:** Amy Lee Consolati

**To:** 'Catherine Heffernan'

**Sent:** Thursday, October 14, 2004 1:45 AM

**Subject:** RE: NOFSW

Dear Catherine,

Forgive me for being unclear in my previous message.

I AM a member (#891) and have been for just over a year. I do have the membership directory. I am seeking permission to use the directory to send a mailing to the membership. I do not want to assume that a direct mailing to the membership is OK without direct confirmation from the Organization's governing body.

Thank you again for your prompt attention to my queries.

Respectfully,

Amy Lee Consolati

-----Original Message-----

**From:** Catherine Heffernan [<mailto:catherine.heffernan@jud.state.ct.us>]

**Sent:** Wednesday, October 13, 2004 11:06 AM

**To:** Amy Lee Consolati

**Subject:** Re: NOFSW

Amy

We have a policy to not release our member mailing list to non-members. As I had suggested, if you join for the \$25 student fee a membership directory will be given to you. Other than placing an ad in our newsletter or providing questionnaires, etc. at our conference in April 2005, this is the best option that I can think of to assist you in accessing our membership.

I'd be happy to assist you in any of these options.  
Just let me know.

Katie

----- Original Message -----

**From:** Amy Lee Consolati

**To:** 'Catherine Heffernan'  
**Sent:** Tuesday, October 12, 2004 11:55 PM  
**Subject:** RE: NOFSW

Dear Catherine,

Thank you again for your assistance with my query.

My research schedule will not allow me to make the necessary deadlines to place an advertisement in the NOFSW newsletter.

Therefore, I am interested in doing a direct mailing to the membership and have two questions regarding that.

First, does the NOFSW have an IRB or any other protocol for obtaining permission to conduct research with its members?

Second, may I purchase or otherwise obtain pre-printed mailing labels?

Warm Regards,

Amy Lee Consolati, MSW Student/Intern  
California State University, San Bernardino

-----Original Message-----

**From:** Catherine Heffernan [mailto:catherine.heffernan@jud.state.ct.us]  
**Sent:** Friday, October 08, 2004 7:38 AM  
**To:** Amy Lee Consolati  
**Subject:** Re: NOFSW

Hello

The deadline for the newsletter is the end of this month I believe. We are trying to produce one on a quarterly basis.

Katie

----- Original Message -----

**From:** Amy Lee Consolati  
**To:** 'Catherine Heffernan'  
**Sent:** Monday, October 04, 2004 12:02 AM  
**Subject:** RE: NOFSW

Dear Catherine,

Thank you for your advice about this.

I am very interested in using the NOFSW membership for my research and need to learn if it will be necessary to get clearance from the Organization's HSRB before soliciting members to participate.

When are the deadlines for advertising in the Newsletter?

Sincerely,

Amy Lee

-----Original Message-----

**From:** Catherine Heffernan  
[mailto:catherine.heffernan@jud.state.ct.us]  
**Sent:** Monday, September 27, 2004 6:41 AM  
**To:** Amy Lee Consolati  
**Subject:** Re: NOFSW

Hello

I am sorry to take so long in responding to you. I have been out of the office. I believe the best way for you to conduct your research with our members would be for you to advertise in our newsletter for volunteers. I will find out more details and get back to you.

Katie

----- Original Message -----

**From:** Amy Lee Consolati  
**To:** 'Katie Heffernan'  
**Sent:** Thursday, September 23, 2004 10:20 PM  
**Subject:** NOFSW

Dear Ms. Heffernan,

My name is Amy Lee Consolati and I am embarking on my final year of study in the MSW program at California State University in San Bernardino, California. My internship placement is at Patton State Hospital, which is a forensic hospital for the criminally insane where I function as a Psychiatric Social Worker.

My thesis/research project involves particular attitudes of forensic social workers, which is why I am writing you this preliminary, informal note. I am interested in learning what procedures are necessary for me to conduct survey research with the members of the NOFSW as respondents. I will be seeking publication of the study upon its completion in June and feel confident that the results will be of interest to many forensic social workers.

I will be happy to provide you with letters of reference and/or any other documentation that the NOFSW may require.

Thank you.

Respectfully,

Amy Lee Consolati  
California State University, San Bernardino  
Patton State Hospital

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